U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 19 December 2006

In the Matter of

D.A.M.
Claimant

v.

OLD RALPH MINING, INC.
Employer

and

ROCKWOOD INSURANCE CO.
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Case No. 2005-BLA-05986

Appearances: Ron Carson, Lay Representative, For the Claimant; Tracey Berry, Esq., Penn Stuart, For the Employer

Before: William S. Colwell, Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. The Act and applicable implementing regulations, 20 CFR Parts 718 and 725, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR

§ 718.201 (2004). In this case, the Claimant, D.A.M., alleges that he is totally disabled by pneumoconiosis.

I conducted a hearing on this claim on October 12, 2005 in Abingdon, Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2004). At the hearing, Director's Exhibits ("DX") 1-36, Administrative Law Judge Exhibits ("ALJX") 1-3, Claimant's Exhibits ("CX") 1-5, and Employer's Exhibits ("EX") 1-10 were admitted into evidence without objection. Transcript ("Tr.") at 9, 10, 13, 14, & 18. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim for benefits on August 25, 1970 with the Social Security Administration. DX 1. After a denial by that department and the Claimant's election that the Department of Labor consider the claim, the Department of Labor also denied the claim on January 16, 1981 for failure to establish any element of entitlement.

The Claimant filed a second claim on April 13, 1993. It was denied by Administrative Law Judge Richard Morgan on December 14, 1998. Although Judge Morgan found that Claimant had established a material change in conditions because he had proven that he was totally disabled, Judge Morgan further found that D.A.M. had failed to establish either the existence of pneumoconiosis or that his disability was due to pneumoconiosis. D.A.M. sought modification of the denial on July 8, 1999. Judge Pamela Lakes Wood issued a Decision and Order on Modification Denying Benefits dated May 16, 2002. Judge Wood found that the evidence did not establish the existence of pneumoconiosis. Thus, she found no mistake of fact or change in conditions since the last denial of the claim. Claimant appealed to the Benefits Review Board ("Board"), which affirmed Judge Wood's denial in an opinion rendered April 24, 2003.

The record shows that no further action was taken until the current claim was filed on May 7, 2004. DX 3. Because it was filed more than one year after the previous denial, it is a subsequent claim governed by § 725.309(d). The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on February 23, 2005, on the grounds that the evidence did not show that the Claimant established the existence of pneumoconiosis or that his total disability was due to pneumoconiosis. DX 28. The Claimant timely appealed that determination, and the case was referred to this office on June 7, 2005. DX 33.

APPLICABLE STANDARDS

Since this claim was filed after January 19, 2001, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2004). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose at least in part out of his coal mine employment, that he is totally disabled, and that the pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004).

ISSUES

After the hearing, the following are the remaining contested issues:

1. Whether the miner has one dependent;

2. Whether the miner has pneumoconiosis as defined by the Act and the regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether he is totally disabled.

5. Whether his total disability is due to pneumoconiosis.

6. Whether he has demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the prior claim was denied.

DX 33; Tr. 6. (Employer conceded that D.A.M. established 32 years of coal mine employment and withdrew that issue along with the issues of whether D.A.M. was a miner, whether his claim is timely filed, and whether Old Ralph Mining, Inc. is the properly designated responsible operator. Tr. 6. Constitutional issues were preserved for appeal.)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Claimant testified to the following. Tr. 19-27. D.A.M. was born October 28, 1933 and was 71 years old at the time of the hearing. DX 3; Tr. 19. His education ended with the fourth grade. At 5'3", D.A.M. weighs 116 pounds. He married O.M. on November 2, 1956. DX 8.

Claimant testified that he last worked in the coal mines in 1992, when he worked at a prep plant for Energy Sales and Service. He was employed as a rock picker, picking rock off the belt for seven to eight months. Prior to that, he worked for Old

Ralph Mining from 1982 to 1988, as a scoop operator in an underground mine. This job required him to scoop the coal out and haul it and dump it in the feeder. It required a lot of exertion, putting D.A.M. under constant stress. While this was his last job of at least one year, he also worked as a Joey loader operator, shuttle car operator, miner's helper, cutting machine helper, and coal drill operator. He described the Joey loader and scoop operator jobs as the dustiest. All his work required heavy lifting, including rock dust bags weighing fifty pounds, shovels, picks, sledge hammers, and very heavy cables. He last worked in 1992, because the mine closed.

D.A.M. first noticed breathing problems in the 1980s. He was first treated for those problems at Stone Mountain Health Center in the 1990s. He currently sees Dr. Roatsey who had prescribed breathing medication and inhalers that he uses daily. He also uses a nebulizer four times a day. Claimant sees Dr. Roatsey every two to three months. He testified that he could not return to coal mining because of his lack of breath.

The Claimant testified that he does not currently smoke but that he began smoking in his mid-20s. He smoked less than half a pack of cigarettes a day and quit about ten years ago.

Dependency

Employer contested the miner's allegation of one dependent and stated at the hearing that it would withdraw this issue based on the Claimant's testimony. The Claimant, however, was not asked about his dependents. The record shows that the one dependent he claims is his wife. They were married on November 2, 1956, and there is no indication that they do not reside together. I find that D.A.M. has one dependent for purposes of augmentation of benefits, his wife.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations are found at 20 CFR § 718.102 (2004) and Appendix A of Part 718. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004).

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH).[1] If no qualifications are noted for any of the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. *See* ***Mullins Coal Co. v. Director, OWCP***, 484 U.S. 135, 145 n. 16 (1987); ***Old Ben Coal Co. v. Battram***, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray/ reading	Readers' Qualifications (all are doctors)	Reading and Film Quality	Result Concerning Presence of Pneumoconiosis
DX 10 4/25/03/ 5/16/03	Aycoth B	2/2; emphysema; scattered rounded and irregular density opacities measuring up to 3 mm in diameter throughout both lungs/ Quality 1	Positive (Claimant's evaluation)
DX 12 4/25/03/ 1/11/05	Scott B, BCR	Negative for pneumoconiosis; hyperinflation compatible with emphysema/Quality 2	Negative (Employer's rebuttal of DX 10)
DX 10 6/14/04/ 6/21/04	Ahmed B, BCR	1/1; emphysema; suspect aneurismal dilatation of the arch of aorta, question of a vague mask right upper lung/Quality 1	Positive (Claimant's evaluation)

[1]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved A and B Readers [as of] August 29, 2005, found at http://www.oalj.dol.gov/PUBLIC/BLACK_LUNG/REFERENCES/REFERENCE_WORKS/BREAD3_08_05.HTM. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

Date of X-ray/ reading	Readers' Qualifications (all are doctors)	Reading and Film Quality	Result Concerning Presence of Pneumoconiosis
DX 12 6/14/04/ 1/11/05	Wheeler B, BCR	Negative for pneumoconiosis; hyperinflation compatible with emphysema/Quality 2	Negative (Employer's rebuttal of DX 10)
DX 9 9/2/04/ 9/2/04	Baker B	1/0/Quality 1	Positive (OWCP's evaluation)
DX 9 9/2/04/ 9/22/04	Barrett B, BCR	Quality 1	Used by District Director for quality reading only[2]
DX 12 9/2/04/ 11/3/04	Scott B, BCR	Negative for pneumoconiosis; hyperinflation compatible with emphysema/Quality 2	Negative (Employer's rebuttal of DX 9)
DX 11 11/19/04/ 11/29/04	Wheeler B, BCR	Negative for pneumoconiosis; hyperinflation lungs compatible with deep breath or emphysema; possible small bleb in or at level of left cardiophrenic angle; few linear scars in lateral periphery left mid lung; can't exclude subtle infiltrate or fibrosis in lateral periphery right upper lung between anterior ribs 2-3/Quality 3	Negative (Employer's evaluation)

[2] Used by the District Director (DD) for a quality reading only. This reading was not submitted or mentioned by either party; and thus, I will not consider it other than as a reading for film quality.

Date of X-ray/ reading	Readers' Qualifications (all are doctors)	Reading and Film Quality	Result Concerning Presence of Pneumoconiosis
DX 13 11/19/04/ 1/26/05	Alexander B, BCR	2/1; Category A large opacities; apparent 12 mm large opacity in right upper zone overlapping posterior fifth rib would be consistent with complicated CWP category A/Quality 2	Positive (Claimant's rebuttal of DX 11)
EX 10 9/12/05/ 9/12/05	Rosenberg B	0/0; emphysema/ Quality 1	Negative (Employer's evaluation)
CX 5 9/12/05 11/20/05	Alexander B, BCR	1/0; emphysema/Quality 1	Positive (Claimant's rebuttal of EX 10)[3]

In response to Dr. Scott's negative interpretation of the April 25, 2003 x-ray, Dr. Aycoth provided a statement dated October 11, 2005, to rehabilitate his positive reading of that film. CX 4. Dr. Aycoth reaffirmed his positive reading.

Similarly, in response to Dr. Wheeler's negative interpretation of the June 14, 2004 x-ray, Dr. Ahmed provided a statement dated October 11, 2005, to rehabilitate his positive reading of that film. CX 3. Dr. Ahmed reaffirmed his positive reading.

Pulmonary Function Test

Pulmonary function tests (PFT) are performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater resistance there is to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for PFTs are found at 20 CFR § 718.103 (2004) and Appendix B. The following chart summarizes the results of the PFTs available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary test, the FEV_1 must be equal to or less than the applicable values set forth in the tables

[3] At the hearing, Employer was permitted to seek a statement from Dr. Rosenberg to serve as rehabilitative evidence in response to Dr. Alexander's rereading of the 9/12/05 x-ray. Tr. 14. In a letter dated January 6, 2006, however, Employer's counsel informed me that no additional evidence was needed.

in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Test Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 10 3/11/03 Narayanan	69 64”	0.92	2.74	33%	23.5	Yes	Moderate obstruction; Found invalid by Dr. Sarah B. Long due to less than optimal effort and the tracings being recorded at too fast a speed. EX 2.
DX 10 1/22/04 Narayanan	70 63”	0.70	1.54	45%	16.5	Yes	Severe obstruction and low vital capacity and possible restriction; Found invalid by Dr. Long due to significantly less than optimal inspiratory effort and spirometric tracings recorded at too fast a speed. EX 1

Ex. No. Test Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 9 9/2/04 Baker	70 62 ½"	0.72	2.42	30%	30	Yes	According to Dr. Kirk E. Hippensteel, who is board certified in internal medicine and pulmonary disease, said the results likely underestimate the miner's true function because the technician suggested sub-optimal effort and the FVC results varied by more than 5%; Found acceptable by Dr. Michos, who is board certified in internal medicine and pulmonary medicine. DX 9.
DX 11 11/19/04 Dahhan	71 161 cm	0.74 0.68	1.75 1.11	42% 61%	23 ---	Yes Yes	Poor cooperation but good understanding

Ex. No. Test Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
EX 8 9/12/05 Rosenberg	71 63”	0.63 0.69	1.56 1.70	40% 41%	16 20	Yes Yes	Severe obstruction, no restriction, borderline bronchodilator response; diffusion capacity corrected for volumes is severely reduced, indicating some loss of alveolar capillary bed; air trapping

Arterial Blood Gas Studies

Arterial blood gas (ABG) studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies are found at 20 CFR § 718.105 (2004). The following chart summarizes the arterial blood gas studies available in this case. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically not advisable. 20 CFR § 718.105(b) (2004).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 9	9/2/04	Baker	42.0	72.0	No	
DX 11	11/19/04	Dahhan	40	66.4	No	
EX 9	9/12/05	Rosenberg	41.1	73.6	No	Normal

Medical Opinions[4]

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis is a substantially contributing cause of the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in 20 CFR § 718.201. See 20 CFR § 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. ***Taylor v. Director, OWCP***, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004).

Where total disability can not be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2004). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2004). Quality standards for reports of physical examinations are found at 20 CFR § 718.104 (2004). The record contains the following medical opinions relating to this case.

Kellie Brooks, MSN, RNCS, FNP

The Claimant submitted records from nurse Kellie Brooks of Stone Mountain Health Services, dated August 31, 1999, January 17, 2000, and November 21, 2000. DX 10. She took a coal mine employment history of almost 41 years, symptoms of a daily productive cough, three-pillow orthopnea, and shortness of breath upon minimal exertion. His medical history was significant for hypertension, COPD, renal calculi, and a hernia repair. Nurse Brooks indicated that D.A.M. did not smoke. Physical examination showed hyperresonance to percussion, diminished breath sounds bilaterally, and scattered expiratory wheezing. She diagnosed dyspnea and respiratory abnormalities and COPD.

Claimant submitted further records from nurse Brooks dated August 22, 2005. CX 2. When she examined the miner that day, she noted complaints of a cough for 20

[4] Employer designated as EX 3 hospital records from Dr. Smiddy of Holston Valley Hospital to be considered under § 725.414(a)(4). EX 3 is a one-page report of a blood gas study taken January 30, 2001. Although it was taken in the hospital, I consider it a blood gas study that would exceed the Employer's limit of two such studies in its case-in-chief. Therefore, I will not consider it in this decision.

years, sputum production, shortness of breath, and two-pillow orthopnea. She listed D.A.M. as a non-smoker. Physical examination showed hyperresonance and diminished breath sounds in all fields. She diagnosed coal workers' pneumoconiosis and severe COPD.

Dr. Smiddy

Claimant submitted the office notes of Dr. Joseph F. Smiddy of the Lonesome Pine Clinic, who saw D.A.M. on April 3, 2003. DX 10. Dr. Smiddy reported 40 years of coal mine employment and symptoms of severe exercise limitation and chronic shortness of breath. He considered medical and family histories. Physical examination showed scattered wheezes and rhonchi. Dr. Smiddy also reviewed the results of a pulmonary function study and referred to a prior positive x-ray. He diagnosed significant chronic bronchitis and coal workers' pneumoconiosis with chronic obstructive lung disease primarily related to coal workers' pneumoconiosis. He relied on multiple chest x-rays that have shown a significant degree of CWP. He noted a profound obstructive ventilatory defect related to the miner's CWP.

Dr. Baker

Claimant was examined by Dr. Glen Baker on behalf of the Office of Workers' Compensation Board on September 2, 2004. DX 9. Dr. Baker considered over 30 years of coal mine employment, most recently as a joy loader and scoop operator, family history, a medical history significant for frequent colds, pneumonia, wheezing, chronic bronchitis, allergies, and high blood pressure, and a history of having smoked less than one pack of cigarettes a day from the 1950s to the 1990s. Claimant complained of a productive cough, wheezing, dyspnea, and two-pillow orthopnea. Physical examination showed bilateral expiratory wheezing. Dr. Baker considered the results of an x-ray, a pulmonary function study, a blood gas study, and EKG. He diagnosed coal workers' pneumoconiosis based on the abnormal x-ray and coal dust exposure; chronic obstructive pulmonary disease with severe obstructive defect based on the pulmonary function test; chronic bronchitis based on history; and hypoxemia based on the blood gas study. He attributed all four conditions to coal dust exposure and added that the last three diagnoses were also due to cigarette smoking. He believed that the miner has a severe impairment with decreased FEV1, decreased PO2, chronic bronchitis, and coal workers' pneumoconiosis. Based on the FEV1 being less than 40% of the predicted value, Dr. Baker assessed a class 4 impairment. He added: "This is 50-100% impairment of the whole person. Due to the nature of his work, he should have no further exposure to coal dust, rock dust or similar noxious agents and would be unable to perform manual labor such as he performed in the mines even in a non-dusty occupation."

Dr. Dahhan

For the Employer, Dr. Dahhan examined the Claimant on November 19, 2004. DX 11. He took an occupational history of 30 years of coal mine employment that was

all underground as a motor man and loader, as well as family and medical histories significant for hypertension. He noted that D.A.M. smoked one-half pack of cigarettes a day from the age of 20 to 65. He considered symptoms of a productive cough and intermittent wheeze, shortness of breath, and being on oxygen for two years. Physical examination showed hyperresonance to percussion, reduced air entry to both lungs, and bilateral wheeze. Dr. Dahhan administered a chest x-ray, pulmonary function study, blood gas study, and EKG. He also reviewed Dr. Baker's examination. Dr. Dahhan found insufficient objective findings to justify a diagnosis of coal workers' pneumoconiosis. He found an obstructive ventilatory defect but felt that the severity could not be assessed because of poor performance and suboptimal effort on Dr. Baker's test. Dr. Dahhan opined that the miner's smoking history more than sufficient to cause chronic obstructive lung disease. In his opinion, D.A.M. does not retain the physiological capacity to continue his previous coal mining job because of his smoking. He found no evidence of any pulmonary impairment due to coal dust inhalation or pneumoconiosis. Dr. Dahhan added that because D.A.M. was being treated with bronchodilators, he assumed that the treating physicians believed the miner's condition responded to such therapy. Thus, the condition could not be coal workers' pneumoconiosis, which is a fixed disease. Finally, Dr. Dahhan stated that D.A.M.'s impairment is severe and disabling and is rarely seen secondary to coal dust inhalation with no evidence of complicated pneumoconiosis or progressive massive fibrosis. Dr. Dahhan is board certified in internal medicine and pulmonary disease.

Dr. Slater

Dr. Kenneth Slater, who is board certified in internal medicine, provided a statement dated May 20, 2005. CX 1. He explained that D.A.M. was first seen at the Stone Mountain Clinic on May 10, 1993, and by Dr. Slater seven months prior to the date of this statement. He noted 32 years of coal mine employment, his status as a non-smoker, symptoms of shortness of breath for over ten years, a productive cough, and wheezing, and the November 19, 2004 x-ray that was read as showing category A large opacities of pneumoconiosis. Dr. Slater opined that D.A.M. has a moderately severe to severe impairment that has decreased his daily living activities. He further felt that the miner's impairment is due at least in part to coal dust exposure.

Dr. Rosenberg

For the Employer, Dr. Rosenberg examined the Claimant on September 12, 2005. EX 7. Dr. Rosenberg is a board certified internist and pulmonologist, as well as a B-reader. He considered a history of smoking less than one pack of cigarettes a day for 40-45 years before quitting in 1995, 33 years of coal mine employment, lastly at the prep plant picking up rocks on the belt. He noted that D.A.M. also worked as a track helper loader, a brakeman, a motorman, a cutter helper, a miner helper, and an operator of a joy loader, shuttle car, and scoop. The Claimant's medical history was significant for pneumonia as a child and being on oxygen, while he complained of shortness of breath on minimal exertion for over twenty years, a regular, productive cough, wheezing, chest pressure, and sleeping trouble. Physical examination revealed

hyperrosonance with markedly diminished breath sounds and a few rhonchi without rales. Dr. Rosenberg also reviewed the results of an x-ray, pulmonary function study, EKG, and blood gas study. He did not diagnose medical or legal coal workers' pneumoconiosis or any associated impairment. Rather, Dr. Rosenberg found disabling chronic obstructive pulmonary disease due to the miner's long history of smoking. He based this on the x-ray evidence, his physical findings, and the pulmonary function study results. Dr. Rosenberg explained that D.A.M. has the characteristic pattern of chronic obstructive pulmonary disease seen in smokers based on the FEV1 percentage of 40%, marked air trapping, and a markedly reduced diffusing capacity.

DISCUSSION AND APPLICABLE LAW

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See* ***Lukman v. Director, OWCP***, 896 F.2d 1248 (10th Cir. 1990); ***Orange v. Island Creek Coal Company***, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> > (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
> >
> > (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the

> miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d) (April 1, 2002).

Claimant's most recent prior claim was denied after Judge Wood determined that Claimant failed to establish the existence of pneumoconiosis. Therefore, in order for Claimant to avoid having his subsequent claim denied on the basis of the prior denial, he must establish this element of entitlement through the newly submitted evidence.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2004).

20 CFR § 718.202(a) (2004) provides that a finding of the existence of pneumoconiosis may be based on evidence from a (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions (not applicable here) described in Sections 718.304, 718.305, or 718.306, or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. In order to determine whether the evidence establishes the existence of pneumoconiosis, I must consider the chest x-rays and medical opinions and analyze whether § 718.304 is invoked – the three categories of evidence applicable in this case. As this claim is governed by the law of the Fourth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 718.202(a).

Pneumoconiosis is a progressive and irreversible disease. ***Woodward v. Director, OWCP***, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See* ***Mullins Coal Co. of Virginia v. Director, OWCP***, 484 U.S. 135, 151-152 (1987); ***Eastern Associated Coal Corp. v. Director, OWCP***, 220 F.3d 250, 258-259 (4th Cir. 2000); ***Crace v. Kentland-Elkhorn Coal Corp.***, 109 F.3d 1163, 1167 (6th Cir. 1997); ***Rochester & Pittsburgh Coal Co. v. Krecota***, 868 F.2d 600, 602 (3rd Cir. 1989); ***Stanford v. Director, OWCP***, 7 B.L.R. 1-541, 1-543 (1984); ***Tokarcik v. Consolidated Coal Co.***, 6 B.L.R. 1-666, 1-668 (1983); ***Call v. Director, OWCP***, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. ***Woodward***, 991 F.2d at 319-320; ***Adkins v. Director, OWCP***, 958 F.2d 49 (4th Cir. 1992); ***Burns v. Director, OWCP***, 7 B.L.R. 1-597, 1-600 (1984).

Of the ten available x-ray readings in this case, five were considered positive for pneumoconiosis while five were found to be negative. There is also one reading made for quality purposes only. For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2004); ***Dixon v. North Camp Coal Co.***, 8 B.L.R. 1-344 (1985); ***Melnick v. Consolidation Coal Co.***, 16 B.L.R. 1-31, 1-37 (1991).

Readers who are board-certified radiologists and/or B readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. ***Scheckler v. Clinchfield Coal Co.***, 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. ***Woodward***, 991 F.2d at 321; *see* ***Adkins***, 958 F.2d at 52. Finally, a radiologist's academic teaching credentials in the field of radiology may be relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See* ***Worhach v. Director, OWCP***, 17 B.L.R. 1-105, 1-108 (1993).

Analysis of X-Ray Studies

The April 25, 2003 x-ray was found positive by Dr. Aycoth, a B-reader[5]. Dr. Scott, who is both a B-reader and a board-certified radiologist, read this film as negative for pneumoconiosis. Both physicians found emphysema present. Dr. Aycoth adjudged the film quality to be 1 while Dr. Scott felt it was quality 2. Dr. Aycoth provided a rehabilitative statement reaffirming his positive reading. I do not find Dr. Aycoth's written statement worthy of any more weight than his x-ray reading alone. Both physicians found the film to be of sufficient quality to make reliable interpretations. Therefore, the difference of opinion regarding the quality of the x-ray does not bear on the weight I place on the readings. Rather, I place greater weight on the Dr. Scott's reading because of his superior credentials for x-ray interpretation. Therefore, I consider this x-ray negative. ***Scheckler***, 7 BLR 1-128.

The June 14, 2004 x-ray was found positive by Dr. Ahmed, a B-reader who is also a board-certified radiologist. He graded the film as quality 1. Dr. Wheeler reread this x-ray as negative and felt it was quality 2. Because a quality 2 x-ray is satisfactory for interpretation, the difference of opinion as to quality does not affect my decision as to this x-ray. Dr. Ahmed provided a rehabilitative statement reaffirming his positive reading. Without any further explanation on Dr Ahmed's part, I do not find that his statement carries any more weight than his x-ray reading alone. Because Dr. Ahmed and Dr. Wheeler share the same excellent credentials for x-ray interpretation, I give their readings equal weight and consider this x-ray to be in equipoise.

[5] Claimant identified Dr. Aycoth as also being a board-certified radiologist. However, www.abms.org, which lists board-certified medical specialists, does not show that Dr. Aycoth is a board-certified radiologist. Dr. Aycoth's curriculum vitae also does not state that he is a board-certified radiologist. DX 10; CX 4. Accordingly, I consider him to be a B-reader but not a board-certified radiologist.

The September 2, 2004 x-ray was found to be quality 1 by Dr. Barrett, a dually certified reader. He read the film only for quality reasons. Dr. Baker, a B-reader, felt the film was also quality 1 and read it as positive for pneumoconiosis. Dr. Scott, a dually certified reader, read the film as negative and found it to be quality 2. I defer to the superior credentials of Dr. Scott and consider this x-ray to be negative for pneumoconiosis.

The November 19, 2004 x-ray was read by Dr. Wheeler, a dually certified interpreter, as quality 3 and negative. Dr. Alexander, also a dually certified reader, reread the film as positive and quality 2. He further detected large opacities. Once again, although Dr. Wheeler adjudged the film as being of poorer quality than Dr. Alexander did, he still found it sufficient to interpret, so the difference in opinion as to quality does not affect my consideration of these readings. Rather, I find that the qualifications of the two physicians are equal, thus entitling their readings to equal weight. Accordingly, I find this film to be in equipoise.

The final x-ray, taken September 12, 2005, was read by Dr. Rosenberg, a B-reader as quality 1 and negative. It was reread by Dr. Alexander, a dually certified reader, as quality 1 and positive. Based on Dr. Alexander's superior qualifications for x-ray interpretation, I find this film positive.

In summary, I have found two x-ray films to be negative for pneumoconiosis, one x-ray film to be positive for pneumoconiosis, and two x-ray films to have readings that are in equipoise. The preponderance of the x-ray films does not support a finding of pneumoconiosis, and therefore, I must find that the Claimant has failed to establish that he suffers from pneumoconiosis by x-ray evidence.

Analysis Under § 718.304

There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if he is suffering from a chronic dust disease of the lung which, on x-ray, yields one or more large opacities classified in Category A, B, or C in the ILO-U/C International Classification of Radiographs of the Pneumoconioses. § 718.304(a)(1).

In this case, there is one reading of Category A large opacities. Dr. Alexander, who is both a B-reader and a board-certified radiologist, interpreted the November 19, 2004 x-ray as quality 2, revealing category 2/1 pneumoconiosis with category A large opacities. DX 13. He noted an apparent 12 mm large opacity in the right upper zone. Dr. Wheeler, a dually certified reader who also interpreted this film, found it negative for pneumoconiosis. I cannot discern that he specifically addressed the 12 mm large opacity seen by Dr. Alexander. He did mention hyperinflation and a possible small bleb at the level of the left cardiophrenic angle. Because these physicians maintain the same credentials, I can find no basis to weigh the reading of one over the other. On the other hand, I find highly persuasive Dr. Alexander's later reading of the September 12, 2005 x-ray—a film that post-dates the November 2004 x-ray by ten months—as

displaying a lesser degree of pneumoconiosis (category 1/0) with no mention of large opacities. He also considered the later film to be of better quality.

Because pneumoconiosis is an irreversible and progressive disease, the category A large opacities could not have disappeared between September 2004 and November 2005. Therefore, I discount Dr. Alexander's earlier reading of large opacities and find that the Claimant has failed to establish, by a preponderance of the evidence, the existence of complicated pneumoconiosis. As a consequence, he has not established the existence of pneumoconiosis pursuant to § 718.202(a)(c), and he is not entitled to the irrebuttable presumption of total disability due to pneumoconiosis pursuant to § 718.304.

Analysis of Medical Opinions

Medical Opinion Guidance

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. ***Hoffman v. B&G Construction Co.***, 8 B.L.R. 1-65, 1-66 (1985); ***Hess v. Clinchfield Coal Co.***, 7 B.L.R. 1-295, 1-296 (1984); ***Justus v. Director, OWCP***, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. ***Fields***, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. ***Clark v. Karst-Robbins Coal Co.***, 12 B.L.R. 1-149, 1-155 (1989) (*en banc*). An unsupported medical conclusion is not a reasoned diagnosis. ***Fuller v. Gibraltar Corp.***, 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. ***Cosaltar v. Mathies Coal Co.***, 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. ***Griffith v. Director, OWCP***, 49 F.3d 184, 186-187 (6th Cir. 1995); ***Justice v. Island Creek Coal Co.***, 11 B.L.R. 1-91, 1-94 (1988); ***Parsons v. Black Diamond Coal Co.***, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. ***Burns v. Director, OWCP***, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. ***Onderko v. Director, OWCP***, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …" ***Tedesco v. Director, OWCP***, 18 B.L.R. 1-103, 1-105 (1994).

Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2004). The Sixth Circuit has interpreted this rule to mean that:

> in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2004) (*internal citations omitted*).

Balancing Conflicting Medical Opinions

The Claimant has also failed to meet his burden of proof to show – by medical opinion evidence – that he has pneumoconiosis. After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinion of Dr. Dahhan for the reasons stated below.

Kellie Brooks diagnosed coal workers' pneumoconiosis. However, § 718.202(a)(4) requires that a medical judgment be made by a physician. Since she is not a physician, I place no weight on her opinion.

Dr. Smiddy diagnosed pneumoconiosis. His opinion was based upon several x-rays that have shown "a significant degree of coal workers' pneumoconiosis." DX 10. However, none of the x-rays to which Dr. Smiddy referred was specified. Therefore, it is not possible to determine whether such x-rays, in fact, support his conclusion. Dr. Smiddy did not address D.A.M.'s smoking history, which may have altered his opinion. ***Stark v. Director, OWCP***, 9 BLR 1-36 (1986). For these reasons, I do not consider Dr. Smiddy's opinion to be well documented and reasoned. ***Fuller v. Gibraltar Corp.***, 6 BLR 1-1291 (1984). Thus, I discount his opinion.

Dr. Baker[6] diagnosed pneumoconiosis. His opinion is well documented, but his x-ray interpretation was reread by Dr. Scott as negative. More importantly, there seems to be no other basis for his diagnosis other than the x-ray, which I found to be negative

[6] Drs. Baker, Dahhan, and Rosenberg share the credentials of board certification in both internal medicine and pulmonary disease. Thus, medical qualifications cannot be used as a basis for weighing one of these physicians' opinions more heavily than another's.

for pneumoconiosis, and D.A.M.'s coal mine employment history. An opinion based on nothing more may be accorded diminished weight. ***Lafferty v. Cannelton Industries, Inc.***, 12 BLR 1-190 (1989); ***Cornett v. Benham Coal, Inc.***, 227 F.3d 569 (6th Cir. 2000). For this reason, I place less weight on Dr. Baker's opinion.

Dr. Slater did not actually diagnose pneumoconiosis but he referred to the November 19, 2004 x-ray that showed not only pneumoconiosis but also the complicated form of the disease. Therefore, I infer that Dr. Slater believes D.A.M. has coal workers' pneumoconiosis. Dr. Slater's statement listed the miner as being a non-smoker but did not address the miner's smoking history. Nor did he note what his findings were upon physical examination. Because of the lack of an accurate smoking history and physical examination, I do not consider Dr. Slater's statement to be adequately documented and reasoned. ***Perry v. Director, OWCP***, 9 BLR 1-1 (1986); ***Minton v. Director, OWCP***, 6 BLR 1-670 (1983). Consequently, I discount his opinion.

Neither Dr. Dahhan nor Dr. Rosenberg diagnosed pneumoconiosis. The x-ray on which Dr. Dahhan relied was found negative by Dr. Wheeler, a dually certified reader. It was also read as positive, however, by Dr. Alexander, who is also dually certified. Therefore, there is some x-ray support for Dr. Dahhan's conclusion. Dr. Dahhan explained that the x-ray findings of emphysema, along with his physical finding of hyperresonance, were consistent with emphysema due to smoking. Accordingly, I find Dr. Dahhan's opinion to be well documented and adequately reasoned, and I place more weight on it.

Dr. Rosenberg's opinion is supported by his own x-ray reading. However, that x-ray was reread by a more highly qualified interpreter as positive for pneumoconiosis. Thus, the x-ray evidence actually belies Dr. Rosenberg's conclusion. Dr. Rosenberg also relied upon the pulmonary function study he administered. However, pulmonary function studies measure disability but do not indicate the presence or absence of pneumoconiosis. Therefore, his reliance on the pulmonary function study to rule out the presence of pneumoconiosis is misplaced. Dr. Rosenberg's physical finding included markedly diminished breath sounds and a few rhonchi without rales. He did not explain how these findings point toward COPD due to smoking but not coal workers' pneumoconiosis. While I consider Dr. Rosenberg's opinion to be well documented, I find fault with his reasoning and, therefore, place less weight on it.

I determine that Dr. Dahhan presented the best documented and reasoned medical opinion. Therefore, I conclude that D.A.M. has failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(4). Further consideration of all the medical evidence under § 718.202(a) leads me to also conclude that the x-ray evidence combined with the most logical and credible medical opinions fails to establish the existence of pneumoconiosis.

Pneumoconiosis Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). Because it is uncontested that Claimant established 32 years of coal mine employment, he would be entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of coal mine employment if he had established the existence of pneumoconiosis.

Total Disability

Judge Morgan found that D.A.M. had established total disability. Therefore, Claimant cannot use this element of entitlement to demonstrate that one of the applicable conditions of entitlement has changed since the date upon which the prior claim was denied pursuant to § 725.309.

Total Disability Causation

As claimant has failed to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a), claimant is precluded from establishing that his totally disabling respiratory impairment is due to pneumoconiosis pursuant to 20 C.F.R. § 718.204(c). *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 19 BLR 2-86 (4th Cir. 1995); *Trent v. Director, OWCP*, 11 BLR 1-26 (1987); *Perry v. Director, OWCP*, 9 BLR 1-1 (1986) (*en banc*). And, as mentioned above, he has not established total disability due to pneumoconiosis through the irrebuttable presumption found at § 718.304.

Summary

In the instant case, D.A.M. has not established the existence of pneumoconiosis pursuant 20 CFR § 718.202(a). Consequently, I find that Claimant has not demonstrated that one of the applicable conditions of entitlement has changed since the denial of his last claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has failed to meet his burden to establish the existence of pneumoconiosis. Consequently, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. *See* Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the

Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by the Claimant on May 7, 2004, is hereby DENIED.

A

WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision